Health Evidence Review Commission

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Outline

- HERC and Prioritized List: history and role
- Prioritized List overview
- HERC public process
- Recent and upcoming work items

Prioritized List history: Context

- Medicaid only covered ‘categorically eligible’ in 1987
  - Pregnant women
  - Children
  - Welfare recipients
  - Aged, blind or disabled
  - Very low-income parents
- Budget dilemma: Cover more services or more people?

Prioritized List history

- Original legislative policy goals
  - Commitment to public process with structured public input
  - Meet budget by reducing benefits rather than covering fewer people
  - Use available resources to fund clinically effective treatments
  - Develop explicit health priorities to guide resource allocation decisions
  - Have an independent body appointed by the governor make Prioritized List decisions

Prioritized List history:

- Bill passed in 1989, creating Health Services Commission (HSC)
  - Created and maintained Prioritized List
- First Prioritized List implemented in 1994
- In 2012, the HERC was formed, replacing HSC
  - Maintains Prioritized List
  - Creates medical technology assessments
- Today's Statute: ORS 414.688-704

See 4/8/2021 EbGS meeting materials for the complete draft report

Continued evolution

- In 2014, the Affordable Care Act Medicaid expansion was implemented
  - Expanded the population eligible for coverage
  - Provided more federal resources
- HERC and the List provide a uniquely transparent public process for making decisions about benefits and coverage criteria

How HERC maintains the List

- Governor appointed; Senate confirmed; staffed by the Oregon Health Authority
  - Two consumer representatives, five physicians, dentist, public health nurse, behavioral health representative, complementary/alternative medicine provider, insurance industry representative, retail pharmacist
- Makes decisions about OHP Covered Services
  - Will OHP cover (insert service here)?
  - When is (service) medically necessary and cost effective?

HERC guiding concepts

- Transparency
- Evidence-based decisions
- Public/patient/provider input and expertise
- Cost-effective services

Prioritized List overview

- Lines 1-662
  - Each line pairs one or more conditions with one or more services
- Funding line: 472 (drawn by legislature, approved by CMS)
- Some things can’t be captured in lines
  - Guidelines and statements of intent
  - Multisector intervention statements

Funded versus unfunded services

Funded services

- Benefits outweigh harms and cost
- Evidence-based
- Safe
- Significant impact on health
- Benefit to populations who have experienced inequities
- Cost effective

Unfunded services

- Ineffective
- Experimental
- Harms outweigh benefits
- Less costly alternatives available
- No significant impact on health
- Specialized care when primary care is sufficient

Prioritized List assumptions

- Diagnostic services are covered
- Ancillary services are covered for funded conditions
  - Prescription drugs
  - Durable medical equipment
  - Other services needed to support covered services (e.g., anesthesia)
- Unfunded services can be covered for a person if they…
  - Improve a funded condition, or
  - Improve a child's ability to grow, develop or participate in school

Sample Prioritized List line

Line number (funding line is 472 for 2022-2023)

Condition/treatment descriptions (brief description of codes listed below)

Reference to guideline notes

Line:	**2**
Condition:	BIRTH OF INFANT (See Guideline Note 153)
Treatment:	NEWBORN CARE
ICD-10:	P00.0-P00.7,P00.81,P00.89-P00.9,P01.0-P01.9,P02.0-P02.1,P02.20-P02.9,P03.0-P03.6,P03.810-P03.9,P04.0, P04.11-P04.9,P05.00-P05.9,P22.1,P29.11-P29.2,P29.4,P29.81-P29.9,P39.3,P92.01-P92.09,P94.1-P94.9,P96.0, P96.3-P96.5,P96.82-P96.89,Q27.0,Z05.0-Z05.3,Z05.41-Z05.9,Z38.00-Z38.8
CPT:	98966-98972,99051,99060,99070,99078,99184,99203-99239,99281-99285,99291-99404,99411-99449,99451, 99452,99460-99463,99468-99472,99475-99480,99487-99491,99495-99498,99605-99607
HCPCS:	G0068,G0071,G0088-G0090,G0248-G0250,G0396,G0397,G0406-G0408,G0425-G0427,G0463,G0466,G0467, G0490,G0508-G0511,G2011,G2012,G2211,G2212,G2214,G2251,G2252

Billing codes (ICD-10 are diagnosis; CPT and HCPCS are procedures.

Sample guideline note

GUIDELINE NOTE 23, COLON CANCER SURVEILLANCE

Line 157

A) History and physical exam is indicated every 3 to 6 months for the first three years after primary therapy, then annually thereafter.
B) CEA testing should be performed every 2-3 months after colon resection for at least two years in patients with stage II or III disease for whom resection of liver metastases is clinically indicated
C) Colonoscopy is indicated every 3 to 5 years.
D) No other surveillance testing is indicated.

Public process

- All meetings are public (and online)
- Anyone can recommend a topic for review
- Topics announced 28 days in advance
- Written and oral testimony accepted on all topics
- Translation and interpretation available

HERC and health equity

Current equity-related work

- Plain language summaries for topics announcements, agendas and meeting materials
- Improved web site and overview
- More active engagement with communities and groups representing those affected by HERC decisions
- Increased recognition of members' experiences, values and preferences as well as gaps in evidence base

Recent and upcoming changes

- Examples of conditions moved above the line in recent years
  - Nonpharmaceutical back pain treatments
  - Uncomplicated inguinal hernias
  - Severe acne
  - Vitiligo
- Upcoming changes (new coverage)
  - Orthodontia for severe malocclusion
  - Nightmare disorder in children
  - PANDAS/PANS (Treatments for mental health symptoms developed after infection in children)

Q & A

Questions?